

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155664</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/13/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>4102 SHORE DR</b> <b>INDIANAPOLIS, IN 46254</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00110188.</p> <p>Complaint IN00110188 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN 00109195 completed on June 13, 2012.</p> <p>Survey dates: July 12 &amp; 13, 2012</p> <p>Facility number: 010666 Provider number: 155664 AIM number: 200229930</p> <p>Survey team: Marcy Smith RN TC Leia Alley RN Dinah Jones RN</p> <p>Census bed type: SNF/NF: 104 Total: 104</p> <p>Census payor type: Medicare: 42 Medicaid: 36 Other: 26 Total: 104</p> <p>Sample: 6</p> <p>Kindred Transitional Care and Rehab-Eagle Creek was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 IN00110188.  Quality review completed on July 17, 2012 by Bev Faulkner, RN			F 000			